Case Study:

California Public Employees' Retirement System (CalPERS)[1]

Introduction

CalPERS has long been regarded as an influential and innovative employer purchaser of health care benefits. CalPERS is the nation's second largest purchaser of health care services, providing health benefits to more than 1.3 million public employees, retirees, and their families, including state and municipal employees and their dependents. Its vision is to "lead in the promotion of health and wellness of our members through best-in-class, data-driven, cost-effective, quality, and sustainable health options for our members and employers."

The CalPERS Shared Savings pilot is a Shared Savings/Global Payment hybrid, in that savings then occurring among the insurer and two contracted provider organizations.

At a Glance…

Time Period	January 1, 2010 to date
Participating Purchaser	CalPERS
Covered Lives	More than 41,000
Participating Providers	Hill Physicians and Catholic Healthcare West's three Sacramento-area hospitals

What motivated CalPERS to pursue its Shared Savings pilot?

The goal at CalPERS is access, quality and affordability of care, in that order. Accountable Care Organizations (ACOs) had been getting attention as a potential vehicle for reorganizing care delivery and payment and Blue Shield suggested creating an ACO for CalPERS that would contain costs.

What are the objectives for the Shared Savings pilot?

- Create a new delivery model that can achieve the economies of a "closed system" model (i.e., Kaiser) and significantly bend health care trend.
- Re-align the incentives between the hospital, medical group and health plan to promote cooperation and integration in a way that is financially viable and beneficial to all parties.
- Develop aggressive cost savings initiatives to take as much of the cost out of the delivery of care as possible, and not just shift cost within the system.
- Achieve zero percent trend for pilot population in Sacramento (as compared to an historical average of 8-12% growth per year).

What is the strategy?

The providers agreed to hold 2010 health care costs for CalPERS members living in the Sacramento to no higher than their 2009 levels. They committed to do so while maintaining their commitments to quality care and patient satisfaction. If they deliver quality care in 2010 at rates less than their 2009 levels, the organizations will share in the savings. If costs rise above their 2009 levels, each organization will share the responsibility for a part of that burden.

The two provider organizations and Blue Shield share a target PMPM cost goal. It is a global three-way budget, but does not change the payment mechanisms or contracts, i.e., the hospital is still paid fee-for-service and the physician group is paid capitation.

The three are all are financially accountable to the global cap. Each partner contributes to achievement of and potentially realizes reward from cost savings and is also at financial risk for any variance from targeted cost reduction goals.

The shared incentive helped get people within the three organizations to truly coordinate care. Specifically, the insurer and provider organizations initiated and implemented the following six strategies:

- **Develop CalPERS-specific utilization management through a coordinated operational infrastructure.** With a goal of reducing fragmentation and duplication related to inpatient services, the organizations integrated data, processes, and care delivery. This included earmarking nurses in the three organizations to coordinate timely sharing of information, enhanced prior authorization, length-of-stay management, and coordinated discharge planning.

- **Eliminate unnecessary utilization and non-compliance through personalization population management.** The organizations stratified their CalPERS members to enhance, leverage and integrate disease management and case management programs. Specific initiatives have included targeted chronic and complex care management, a comprehensive palliative care program, a new case management program focused on chronic pain, and data collection process and integration.

- **Improve physician clinical and resource variation through quantitative analysis and targeted interventions.** The organizations developed a provider "pyramid" of high and low performers for selected high-cost procedures and diseases to remove variation in clinical care and resource utilization. Specific areas of focus have included ER utilization**,** educating and monitoring physicians on outlier behavior based on accepted protocols for specific services (e.g., knee and hip replacement, bariatric surgery, and OB/GYN care), and outpatient surgery redirection to Catholic Healthcare West hospitals.

- **Reduce pharmacy costs and utilization through directed member outreach, drug purchasing and contracting strategies**. Specific strategies have included high-touch programs to move members from brand to generic drugs, eliminating partial prescriptions from the hospital to get the member a 90-day supply at discharge, and reducing the cost of injectable drugs.

- **Facilitate the rapid and efficient communication of patient medical information through IT integration.** The parties have advanced the adoption and effective use of technologies and tools by all physicians caring for the target patient population. Initiatives have included increasing the adoption and use of existing technologies (e.g., NextGen, Mobile MD) to facilitate the rapid and efficient communication of patient medical information to care providers and interconnecting the organizations' technologies to streamline processes and support consistent communication, creating a master patient index to support a common database of members, identifying all active registries and developing automatic updates on program enrollment and disenrollment to support seamless patient communication, and enabling patient-focused health care through a personal health record.

- **Develop a comprehensive dashboard of leading and lagging measurements.** The dashboard shows the parties how they are doing on the risk share arrangement. Once a month it details important measures, including: hospital admissions per 1000 members, readmissions per 1000; members, the generic prescription drug use rate; and some

procedure-specific information (e.g., hysterectomy, knee and hip replacement, and bariatric surgery use rates).

CalPERS played a critical role in the initiative, serving as an active partner rather than merely as a passive purchaser. It created incentives for employees and dependents to choose the specific HMO health benefit plan with its smaller network, offering enrollees a premium discount for their selection of the plan.

What challenges have Blue Shield and the providers faced with the strategy?

- The work required a great deal of planning – efforts started in 2007 and agreements were signed in April 2009 for a January 1, 2010 start date.
- A great culture shift was required. Each party had to be willing to share data and not be afraid that the information would be held against it. It was huge step for Blue Shield to share its pricing tool with providers, but it developed the trust to do so.
- Obtaining hospital provider buy-in to move away from the existing fee-for-payment system.
- The three organizations' disparate systems didn't "talk" to one another. This remains an ongoing challenge, but progress has been made towards rectifying it.

What results have been achieved?

- The shared goal was $15.5 million in savings. The partnering organizations achieved, and may potentially exceed, their original savings goal.
- CalPERS believes that the pilot program achieved its goals, and CalPERS applauds the good work of Blue Shield, Hill Physicians and Catholic Healthcare West.

What advice does Blue Shield have for employers?

- It is critical to have all three players (insurer, physician group and hospital(s)) willing to coordinate and align toward a common goal. There must be a mutual willingness of the plan and providers to be transparent with each other. The trust to do so took over a year to establish.
- The model works best for fully insured members, because there is an upside to the parties to do this. Arrangements for self-insured employers would need to be built in a different way.

What advice does CalPERS have for employers?

- One cannot overstate the importance of coordination of care for each of its members. People with challenging health care situations have reported that they didn't have to repeat their history multiple times because their care was coordinated. Cost effective care and reductions in unnecessary care will improve the overall quality of care for each member.

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[1] Interview with and documentation provided by Juan Davilia and personal communication with Johnny Wong, Blue Shield of California; personal communication with Kathleen Billingsley, CalPERS; presentation by Wade Rose of Catholic Healthcare West and Mike Johnson of Blue Shield of California, available at http://www.newamerica.net/blog/new-health-dialogue/2009/hc4hr-sharing-savings-health-reform-13380; and Simmons KJ. "Large Healthcare Purchaser Takes Risky Leap Into ACOs", HealthLeaders Media, April 8, 2010, http://www.healthleadersmedia.com/content/QUA-249275/Large-Healthcare-Purchaser-Takes-Risky-Leap-Into-ACOs.

This case study was created for the National Business Coalition on Health's Value-Based Purchasing (VBP) Guide.

For more information on the VBP Guide, please visit www.nbch.org/vbpguide.